New Sections

WAC 296-20-01010 Scope of Health Care Provider Network

(1) The chapter establishes rules for the development, enrollment, and oversight of a network of health care providers approved to treat injured workers. The health care provider network rules apply to care for workers covered by Washington State fund and self-insured employers.

(2) As of January 1, 2013, the following types of health care providers must be enrolled in the network with an approved provider contract to provide and be reimbursed for care to injured workers in Washington State beyond the initial office or emergency room visit:
- (a) Medical physicians and surgeons;
- (b) Osteopathic physicians and surgeons;
- (c) Chiropractic physicians;
- (d) Naturopathic physicians;
- (e) Podiatric physicians and surgeons;
- (f) Dentists;
- (g) Optometrists;
- (h) Advanced registered nurse practitioners; and
- (i) Physician assistants.

(3) The requirement in (2) above does not apply to providers in the following specialties who practice exclusively in acute care hospitals or within inpatient settings:
- (a) Pathologists;
- (b) Consulting radiologists working within a hospital radiology department;
- (c) Anesthesiologists, except anesthesiologists with pain management practices in either hospital based or ambulatory care settings;
- (d) Emergency room physicians; or
- (e) Hospitalists.

(4) The department may phase implementation of the network to ensure access within all geographic areas. The department may expand the provider network scope to include additional health care providers not listed in (2) and to out of state providers. For providers outside the scope of the provider network rule, the department may reimburse for treatment beyond the initial office or emergency room visit.

WAC 296-20-01020 Minimum Health Care Provider Network Standards

To be eligible for enrollment and participation in the provider network, a provider must meet and maintain the following minimum health care provider network standards:

(1) The provider must submit an accurate and complete provider application, including any required supporting documentation and sign without modification, a provider contract with the department.

(2) The provider must be currently licensed, certified, accredited or registered according to Washington state laws and rules or in any other jurisdiction where the applicant treats injured workers.
   (a) The license, registration or certification must be free of any restrictions, limitations or conditions relating to the provider's clinical practice.
   (b) The provider must not have surrendered, voluntarily or involuntarily his or her professional state license in any state while under investigation or due to findings by the state resulting from the provider's acts, omissions, or conduct.
   (c) The department may grant an exception for any restriction, limitation or condition deemed by the department to be minor or clerical in nature.

(3) The provider must have a current Drug Enforcement Administration (DEA) registration, if applicable to the provider's scope of practice.
   (a) The DEA registration must be free of restrictions, limitations or conditions related to the provider's acts, omissions or conduct.
   (b) The provider must not have surrendered, voluntarily or involuntarily his or her DEA registration in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct.
   (c) The department may grant an exception for any restriction, limitation or condition deemed by the department to be minor or clerical in nature.

(4) The provider must have either:
   (a) Clinical admitting and management privileges, in good standing, if the provider's scope of practice includes hospital care; or
   (b) An inpatient coverage plan with participating practitioner(s), hospitalists, or inpatient service teams for the purpose of admitting patients. Any inpatient coverage plan must be specified by the provider and found to be acceptable by the department.
   (c) The provider must not have surrendered, voluntarily or involuntarily, his or her hospital privileges in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct.

(5) The provider must have current professional liability coverage, individually or as a member of a group, through a commercial carrier or provide documentation of self-insurance.

(a) Professional liability coverage must be at least in the amounts of $1 million individual occurrence and $3 million annual aggregate or in the amounts otherwise specified by the department for the provider's scope of practice.

(b) Self-insured providers must provide evidence of " committed assets", by a recognized entity in the amounts specified in (5)(a). "Committed assets" means assets that are dedicated solely to the purpose of payment of professional liability claims and cannot be accessed by general creditors or any of the providers.

(6) The provider must not have any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary board at the time of application or re-credentialing.

(a) The department may grant an exception for any restriction, limitation or condition deemed by the department to be minor or clerical in nature.

(7) The provider must not have been excluded, expelled or suspended from any commercial or federally or state funded programs, including but not limited to Medicare or Medicaid programs or private insurers.

(8) The provider must not have been convicted of a felony or pled guilty to a felony for a crime, including but not limited to, health care fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of controlled substances.

(a) The department may grant an exception for a felony that has been expunged (vacated criminal conviction) from the provider's record.

(9) The provider must not have made any material misstatement or omission to the department concerning licensure, registration, certification, disciplinary history or any other material matter covered in the application or credentialing materials.

WAC 296-20-01030 Health Care Provider Network Enrollment

(1) The department or its delegated entity will review the provider's application, supporting documents, and any other information requested or accessed by the department that is relevant to verifying information, or the provider's clinical experience and ability to meet or maintain provider network requirements.

(2) The department will notify providers of incomplete applications, including when credentialing information obtained from other sources materially varies from information on the provider application. Incomplete applications will be rejected 45 days after notification. The provider may submit a supplement to the application with corrections or supporting documents to explain discrepancies.

(3) The provider is responsible for producing adequate and timely information and timely attestation to support evaluation of the application, including but not limited to: competence, character, ethics, mental and physical health status, and other qualifications relevant to the application. The provider is responsible for producing information and responding to department requests for information that will help resolve any questions regarding qualifications within the timeframes specified in the application or by the department.

(4) The department's medical director or designee in writing has the authority to approve, deny, or further review complete applications.

(5) Providers who meet the minimum provider network standards, have not been identified for further review, and are in compliance with department rules and policies, will be approved for enrollment into the network.

(6) Enrollment of a provider is effective no earlier than the date of the approved provider application. The department will not pay for care provided to workers prior to application approval, regardless of whether the application is later approved or denied, except as provided in this subsection.

(7) The department may pay a provider without an approved application only when:
   a. The provider is outside the scope of the provider network
   b. The provider is provisionally enrolled by the department after it obtains:
      i. Verification of a current, valid license to practice;
      ii. Verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the national practitioner data bank (NPDB) or healthcare integrity and protection databank (HIPDB) query; and
      iii. A current and signed application with attestation.
      iv. A provider may only be provisionally enrolled once and for no more than sixty (60) calendar days. Providers who have previously participated in the network are not eligible for provisional enrollment.

WAC 296-20-01040 Health Care Provider Network Continuing Requirements

(1) To continue to provide care for workers and be paid for those services, a provider must:

a. Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;

b. Provide all services according to federal and state laws and rules, department rules, policies, and billing instructions;

c. Maintain compliance with minimum provider network standards, department credentialing standards, and department rules and policies;

d. Inform the department of any material changes to the provider's application or contract within seven (7) calendar days, including but not limited to, changes in:

i. Ownership or business name;

ii. Address or telephone number;

iii. Professionals practicing under the billing provider number;

iv. any informal or formal disciplinary order, decision, disciplinary action or other action(s), including any criminal action, in any state;

v. changes to provider clinical privileges;

vi. malpractice coverage or claims

e. Retain a current professional state license, registration, certification and/or applicable business license for the service being provided, and update the department of all changes;

f. Comply with department re-credentialing process; and

g. Comply with the instructions contained in a department action, including documentation of compliance and participation in mentoring, monitoring, or restrictions.

WAC 296-20-01050 Health Care Provider Network Denial and Further Review

(1) The department may further review a complete provider application based on information within the application or credentialing information obtained from other sources.

(2) For complete applications requiring further review, the department's medical director or designee may seek advice, expertise, consultation or recommendations on applications from:

a. Peer or clinical review individuals or entities;

b. The industrial insurance medical or chiropractic advisory committee (including a subcommittee);

c. A department appointed credentialing committee

(3) The department may deny a provider application for enrollment in the provider network provider based on the provider's professional qualifications and practice history, including, but not limited to the following:

(a) The provider fails to meet minimum health care provider network standards

(b) The provider has been disciplined based on allegation of sexual misconduct or admitted to sexual misconduct;

(c) The provider is noncompliant with the Department of Health's or other state health care agency's stipulation to informal disposition (STID), agreed order, or similar licensed restriction;

(d) The provider is suspended or terminated by any federal or state agency that arranges for the provision of healthcare or a commercial insurance carrier;

(e) The provider has a denial, suspension or termination of participation or privileges by any health care institution, plan, facility, or clinic;

(f) The provider has significant malpractice claims or professional liability claims (based on materiality to current practice, severity, recency, frequency, or repetition);

(g) The provider has been noncompliant with the department's rules, guidelines, evidence based best practice treatment guidelines, coverage policies, or administrative and billing policies;

(h) The provider was or is involved in acts of dishonesty, fraud, deceit or misrepresentation that, in the department's determination, could relate or impact, the provider's professional conduct or the safety or welfare of injured or ill workers; or

(i) The provider committed negligence, incompetence, inadequate or inappropriate treatment or lack of appropriate follow-up treatment which results in injury to a worker or creates unreasonable risk that a worker may be harmed.

(j) The provider uses healthcare providers or healthcare staff who are unlicensed to practice or who provide health care services outside their recognized scope of practice or the standard of practice in Washington state;

(k) The provider with a history of alcohol or chemical dependency fails to furnish documentation demonstrating that the provider is complying with all conditions limitations, or restrictions to the provider's practice both public and private and receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice;

(l) The provider has Informal licensure actions, conditions, agreements, orders;

(m) The provider is currently active, but has a history of probation, suspension, termination, revocation or a surrendered professional license, certification, accreditation, or registration listed in the National Provider Data Bank/Healthcare Integrity and Protection Data Bank or any like entity; or by a state authority in any jurisdiction, including but not limited to, the Washington State Department of Health, when such charges involve conduct or behavior as defined under chapter 18.130.RCW, Uniform Disciplinary Act;

(n) There is evidence of fraud, abuse or other billing irregularities that result in inappropriate payment;

(o) There are complaints or allegations demonstrating a pattern of behavior(s) or misrepresentations which is a cause of concern, including, but not limited to complaints, allegations, incidents, misconduct, inappropriate controlled substance prescribing pattern;

(p) The provider has a criminal history, which includes, but is not limited to any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas; or

(q) A finding of risk of harm pursuant to WAC xxx

(4) The department and self-insurers may not pay for any care to injured workers, other than an initial visit, by a provider whose application has been denied.

WAC 296-20-01060 Delegation of Credentialing and Recredentialing Activities

(1) The department may delegate credentialing and recredentialing review activities to the following entities:
   (a) medical group(s) and clinics,
   (b) physician organizations,
   (c) credentials verification organizations (CVO's), or
   (d) other organizations that employ and/or contract with providers.

(2) Any delegation by the department of credentialing or recredentialing review activities will be documented through a written delegation agreement.

(3) The department retains the right to review, approve, suspend, deny, or terminate any provider who has been credentialed by a delegated entity.

WAC 296-20-01070 Waiting Periods for Reapplying to the Network

(1) Providers are not eligible to reapply for enrollment in the network if they have been denied or removed from network participation due to:
   (a) A finding of risk of Harm, pursuant to WAC 296-20-xxx;
   (b) Having been excluded, expelled or suspended from any federally or state funded programs, including but not limited to Medicare or Medicaid programs;
   (c) Having been convicted of a felony or pled guilty to a felony for a crime, including but not limited to, health care fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of controlled substances;
   (d) Sexual Misconduct as defined in profession specific rules of any state or jurisdiction, including Washington State Department of Health.

(2) Providers who are denied or removed from the network or terminated for any other reason than those set forth in (1) above are not eligible to reapply for enrollment in the network for five (5) years.

WAC 296-20-01080 Department Action

This section is undergoing final drafting and will be presented at the meeting

WAC 296-20-01090 Request for Reconsideration of Department Decision

(1) A provider may request reconsideration of the decision of the department's decision to deny enrollment or remove a provider from the health care network, or terminate a contract for cause. The request for reconsideration must be received by the department within thirty (30) calendar days from the date of notice of the department decision.

(2) Providers must:
   (a) Specify the department decision that the provider is disputing;
   (b) State the basis for disputing the department's decision; and
   (c) Include documentation to support the provider's position.

(3) The department may request additional information or documentation. The provider must submit the additional information within thirty (30) calendar days of the date on the department's request.

(4) The department will review the original decision, information supporting the original decision, the provider's reconsideration request and supporting documentation and will notify the provider of its reconsideration decision.

WAC 296-20-01100 Risk of Harm *(as approved by IIMAC)*

1) It is the intent of the Department, through authority granted by RCW 51.36.010 to protect workers from physical or psychiatric harm by identifying, and taking appropriate action, including removal of providers from the Statewide network, when:
   a) there is **harm**, and
   b) there is a **pattern(s)** of **low quality care**, and
   c) the harm is related to the pattern(s) of low quality care.

2) It is not the intent of the Department to remove or otherwise take action when providers are practicing within Department policies and guidelines, or within best practices established or developed by the Department, or established in collaboration with its Industrial Insurance Medical and Chiropractic Advisory Committees.

3) The department may permanently remove a provider from the state-wide network or take other appropriate action when that provider's treatment of injured workers exhibits a pattern or patterns of conduct of low quality care that exposes patients to a risk of physical or psychiatric harm or death.

4) Harm is defined as (intended or unintended) physical or psychiatric injury resulting from, or contributed to, by health care services that result in the need for additional monitoring, treatment or hospitalization or that worsens the condition(s), increases disability, or causes death. Harm includes increased, chronic, or prolonged pain or decreased function.

5) Pattern or patterns of low quality care is/are defined as including one or more of the following:
   a) For health services where the Department can calculate normative data on frequency, a provider's cases are in the lowest decile (at or below the 10^{th} percentile); or
   b) For health services where the Department cannot calculate normative data on frequency, at least 20% of requested or conducted services meet the definition of low quality care; or
   c) For health services where department data or scientific literature has reported expected rates of adverse events, a provider's adverse event rates are at least 20% above the expected rate; or
   d) A review of a random sample of the provider's cases demonstrates that at least 20% of cases do not meet peer matched criteria for acceptable quality; or
   e) Two or more deaths or life threatening events; or
   f) Provider behavior(s) and/or practices that result in revocation or limitation of hospital privileges or professional licensure sanctions.

6) Low quality care in the statewide workers' compensation network is defined as treatments or treatment regimens:
   a) That have not been shown to be safe or effective or for which it has been shown that the risks of harm exceed the benefits that can reasonably be expected, based on available peer-reviewed scientific studies; or
   b) That uses diagnostic tests or treatment interventions not in compliance with the Department's policies, the Department's applicable utilization review criteria, or the Department's guidelines; or
   c) That includes repeated unsuccessful surgical or other invasive procedures; or
   d) That is outside the provider's scope of practice or training; or

e) That results in revocation or limitation of hospital privileges or in professional licensure sanctions; or
f) That fails to include or deliver appropriate and timely health care services as identified in available Department guidelines or policies; or
g) That includes repetitive provision of care that is not curative or rehabilitative per WAC 296-20-01002 for extended periods that does not contribute to recovery, return to work, or claim resolution; or
h) That includes repeated testing, including but not limited to routine use of a diagnostic test or procedure by either the provider prescribing or the provider performing the test, when any of the following apply:
    i) The test(s) have been demonstrated to be unsafe or of poor quality; or
    ii) high quality, peer-reviewed scientific studies do not show that the test has the technical capacity (reliable and valid) and accuracy to result in successful clinical outcomes for their intended use (utility); or
    iii) the test is conducted or interpreted in a manner inconsistent with high quality evidence based clinical practice guidelines; or
    iv) the test is likely to lead to treatment that does not meet Department guidelines or policies or is otherwise harmful.

7) Appropriate action(s) by the Department may include, but are not limited to:
    a) Monitoring the provider
    b) Mentoring the provider
    c) Restricting payment for services rendered by the provider
    d) Suspending the provider from the network
    e) Permanently removing the provider from the network

    The Department must first notify the provider, and may take action in any order or combination, depending on the severity of the risk of harm. In cases where imminent or actual harm is not life-threatening or substantially disabling, the Department may provide an opportunity for the provider to change through education and other means first.

8) In taking appropriate action, the Department will take into account any unique mitigating circumstances related to the clinical severity and complexity of the providers' patient population. Unique mitigating circumstances could include practice at a care facility recognized for its receipt of particularly severe cases, such as catastrophic injuries. Duration of disability and/or chronic pain shall not, in and of themselves, be considered uniquely mitigating.

9) The Department may not take action against a provider if harm was related to an isolated instance of health care service delivery that was:
    a) Conducted within coverage policies and treatment guidelines established by the department or other evidence-based coverage decisions made by the Washington State Health Technology Committee, or the Prescription Drug Program AND
    b) Necessitated by unique circumstances related to the severity or complexity of the patient's specific condition.